Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2681HOS	A. BUILDING _____ B. WING _____	05/08/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROGRESSIVE HOSPITAL	4015 SOUTH MCLEOD LAS VEGAS, NV 89121

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments This Statement of Deficiencies was generated as a result of a State Licensure survey conducted at your facility on 05/05/09 though 05/08/09, in accordance with Nevada Administrative Code, Chapter 449, Hospitals. The census at the time of the survey was 14 patients. Fourteen patient files were reviewed. Six closed patient files were reviewed. Twenty four employee files were reviewed. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified.	S 000		
S 070 SS=D	NAC 449.3154 Construction Standards 1. Except as otherwise provided in this section, a hospital shall comply with the provisions of NFPA 101: Life Safety Code, pursuant to section 1 of this regulation. This Regulation is not met as evidenced by: The current edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) is the 2006 edition, using Chapter 18, "New Health Care Occupancies."	S 070		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Rosemary Thiele TITLE CEO (X6) DATE 6-12-09

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S 070	Continued From page 1 This REG is not met as evidenced by: 1) Chapter 8 Features of Fire Protection 8.3 Fire Barriers 18.3.7.5 Materials and methods of construction used for required smoke barriers shall not reduce the required fire resistance rating. Based on observation on 5/21/09, the facility failed to maintain the fire resistance rating of the 1 hour fire/smoke wall for 1 of 3 fire/smoke walls in the building. Findings include: The southeast fire/smoke wall had 1 inch and 1/2 inch flexible conduit penetrating the 1 hour fire wall. These conduits were not caulked with fire caulk to seal against the passage of smoke in a fire. There was also a 2 inch water line that was not fire caulked to seal against the passage of smoke in a fire. 2) Chapter 18.3 Protection 18.3.2 Protection from Hazards 18.3.2.1 Hazardous Areas. Any hazardous areas shall be protected in accordance with Section 8.7, and the areas described in Table 18.3.2.1 shall be protected as indicated. Table 18.3.2.1 Hazardous Area Protection Soiled linen rooms 1 hour Separation/Protection 8.7.1.3 Doors in barriers required to have a fire	S 070	8.3 Fire Barriers tag S070 A) Support Services Director applied 3M Fire Barrier Sealant CP25WB+ around flexible conduit and 2 inch water pipe to seal against the passage of smoke in a fire. Attachment # 1 MSDS sheet for 3M fire sealant. B) All staff and patients have the potential to be affected by openings in fire barriers do to construction. C) Environmental staff will observe any work done which may affect Barrier protection. D) Fire barrier seals will be visually inspected monthly by Environmental staff, and documented in the monthly facility checklist. Attachment # 2 facility checklist. E) Support Services Director monitors checklist for compliance and retains it in the Environment of care book in the engineering office. F) Corrected 5/21/2009. Attachment # 3, digital photos of barriers. RECEIVED JUN 12 2009 BUREAU OF LICENSURE AND CERTIFICATION LAS VEGAS, NEVADA	

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S 070	Continued From page 2 resistance rating shall have a 3/4 hour fire protection rating and shall be self-closing or automatic-closing in accordance with 7.2.1.8. Based on observation, the facility failed to provide the proper fire-rated door for a hazardous area. Findings include: The south-west soiled laundry room had a 20 minute fire-rated door. 3) 7.9 Emergency Lighting 7.9.2.4 Emergency generators providing power to emergency lighting systems shall be installed , tested , and maintained in accordance with NFPA 110, Standards for Emergency Lighting and Standby Powers Systems. NFPA 110 8.4.3 Diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent nameplate rating for 30 minutes, followed by 75 percent nameplate rating for 60 minutes, for a total of 2 continuos hours. Based on record review, the facility failed to perform the required annual 2-hour load bank test for the emergency generator. Findings include: The facility only had proof of a 1-hour load bank	S 070	2) Chapter 18.3 Protection Section 8.7.1.3 – Tag S070 A) 5/21/09 quote for New fire rated door for soiled laundry room. Attachment # 4 B) Potential to affect all staff and patients if a fire were to occur in the soiled linen room, having a rating less than is required. C) Doors and door frames will be checked for their ratings and ensure that they are in proper working order no less than monthly. D) Doors and their fire ratings added to monthly facility check list, and will be kept in the environment of care book in the engineering office. Attachment #2 E) Support Service Director monitors checklist for compliance and retains in the Environment of Care book in engineering office. F) 6/4/09 Door delivery error – attachment #5. New door quote and order on 6/5/09 with anticipated delivery and install of new 90 min fire rated door no later than 7/21/2009. Attachments #6 and 7. 3) Emergency lighting – Tag S070 A) 5/21/09 a 90 minute load test was conducted by our vendor on the Diesel powered EPS. Attachment # 8 B) During a power failure all staff/patients may be affected by testing deficiencies. C) 2 hour load bank testing amendment to GEN-TECH contract - attachment # 9. D) Quarterly PM and 2 hour load testing conducted by the vendor and tracked on log sheet by Support Services Director – attachment #10.	

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S 070	Continued From page 3 test dated 2/16/09 performed by their vendor. Severity: 2 Scope: 1	S 070	E) Load tests and PM monitored by Support Services Director; a copy of testing kept in the Environment of care book in the engineering office. F) 2 hour load test conducted 6/11/09 per SOD – attachment # 11	
S 219 SS=F	NAC 449.340 Pharmaceutical Services 5. Drugs and biologicals must be controlled and distributed in a manner which is consistent with applicable state and federal laws. This Regulation is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure expired medications were not stored at the facility. Findings include: On 05/05/09 at 9:00 AM, the following expired medications were stored inside the facility's medication room. 1. One 1000 cc (cubic centimeter) IV (intravenous) bag 10% Dextrose solution with an expiration date of 09/08. 2. One bottle of Vancomycin 250 mg (milligram)/5cc oral solution located inside the medication room refrigerator with an expiration date of 04/23/09. 3. One bottle of Vancomycin 250mg/5cc oral solution located inside the medication room refrigerator with an expiration date of 05/03/09. 4. One 30 cc vial of Acetylcysteine solution with an expiration date of 09/01/08. 5. One 16 fluid ounce bottle of Hydrogen peroxide located under the nursing station sink with an expiration date of 05/06.	S 219		

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S 070	Continued From page 3 test dated 2/16/09 performed by their vendor. Severity: 2 Scope: 1	S 070	S 219 NAC 449.340 Pharmaceutical Services	
S 219 SS=F	NAC 449.340 Pharmaceutical Services 5. Drugs and biologicals must be controlled and distributed in a manner which is consistent with applicable state and federal laws. This Regulation is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure expired medications were not stored at the facility. Findings include: On 05/05/09 at 9:00 AM, the following expired medications were stored inside the facility's medication room. 1. One 1000 cc (cubic centimeter) IV (intravenous) bag 10% Dextrose solution with an expiration date of 09/08. 2. One bottle of Vancomycin 250 mg (milligram)/5cc oral solution located inside the medication room refrigerator with an expiration date of 04/23/09. 3. One bottle of Vancomycin 250mg/5cc oral solution located inside the medication room refrigerator with an expiration date of 05/03/09. 4. One 30 cc vial of Acetylcysteine solution with an expiration date of 09/01/08. 5. One 16 fluid ounce bottle of Hydrogen peroxide located under the nursing station sink with an expiration date of 05/06.	S 219	A. Memo distributed to Nursing Department dated 5-11-09 regarding medication storage. Attachment # 12 Memo from THC Pharmacy Supervisor to THC staff dated 6-10 regarding medication storage. Attachment #13 B. All patients have the potential to be affected by deficient practice. C. On 5-15-09 @ mandatory Nursing staff meeting, the medication room responsibilities reviewed with staff. 6/10/09 Medication Room Log initiated, to be signed by nurse assigned to medication room responsibilities. Attachment # 14 Resource Nurse will verify that medication room assignment is carried out and documented verification on Resource RN Check list. Attachment # 15 D. Log and check list will be reviewed by CNO weekly to ensure compliance so deficient practice will not recur. E. CNO responsible for monitoring & compliance F. Correction 6/10/09	

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S 219	Continued From page 4 6. One 4 ounce bottle of Bausch Lomb eye wash irrigation solution located under the nursing station sink with an expiration date of 05/03. On 05/05/09 at 9:00 AM, Employee #1 confirmed the expiration dates on the above listed medications and indicated it was the nursing and pharmacy staffs responsibility to check the medications at the facility for expiration dates and remove all expired medications from stock for destruction. Employee #1 indicated a nurse was assigned each shift to check the medication room for expired medication and remove any expired medications from stock. The expired medications were then returned to the pharmacy for destruction. The facility's Medication Storage Policy dated 04/03 indicated all outdated, contaminated or deteriorated medications and those in containers that were cracked, soiled, unlabeled or without closures were immediately removed from stock, disposed of according to procedures for medication destruction, and reordered from the pharmacy, if a current order existed. Severity: 2 Scope: 3	S 219		
S 298 SS=E	NAC 449.361 Nursing Service 9. A hospital shall ensure that its patients receive proper treatment and care provided by its nursing services in accordance with nationally recognized standards of practice and physicians' orders. This Regulation is not met as evidenced by: Based on observation, interview, record review and policy review, the facility failed to ensure patients received proper treatment and care	S 298	S298 NAC 449.361 Nursing Service A. To ensure that all patients receives proper treatment and care by Progressive Hospital nursing staff B. All patients have the potential to be affected by deficient practice.	

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S 298	Continued From page 5 provided by nursing services in accordance with facility policies and physicians' orders. Findings include: 1. a. Patient #6 On 5/6/09 in the morning, Employee #4 removed the following medications from the facility's medication dispenser/bulk supply for Patient #6: Carvedilol 25 milligrams at 10:30 AM Isosorbide 30 milligrams at 10:30 AM Omeprazole 20 milligrams at 10:30 AM Ferrous Sulfate 325 milligrams at 10:30 AM Employee #4 administered the above four medications at 10:30 AM. Patient #6 took the Ferrous Sulfate tablet without food. Patient #6's physicians' orders and medication administration record (MAR) indicated the above medications were ordered to be administered at 9:00 AM with the exception of Ferrous Sulfate. Ferrous Sulfate was scheduled with meals at 8:00 AM and 12:00 PM. Chapter 5.003 of the facility's medication administration policy under sub-heading #10, which was last revised in April 2003, indicated "medications are administered with one hour before and one hour after the scheduled time..." On 5/8/9 at 11:15 AM, Employee #1 indicated the medication parameters for 9:00 AM daily medications would be 8:00 AM to 10:00 AM, an hour before and an hour after 9:00 AM.	S 298	S 298 continued from page 5 C. On 5-15 -09 @ the monthly nursing staff meeting medication administration Policy and Procedures reviewed with nurses. Attachment # 16. Minutes and attendance sheet Post test given to nurses after review with a minimum passing grade of 80% Employee # 4 written counseling on 5/17/09. 1:1 reviewed of medication administration policy, following physician orders for med administration, scheduled administration times, and Medication record documentation. D. THC pharmacist to complete monthly observation of medication administration with documented findings. These findings will be review with the individual nurse and the CNO E. CNO ultimately responsible for monitoring compliance. F. Correction completed 5/15/09. Observation of medication passes scheduled the first week of each month	

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S 298	Continued From page 6 Chapter 5.003 of the facility's medication administration policy under sub-heading #13 indicated "if a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time..., the space provided on the front of the [MAR] for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for [as needed] documentation." Patient #6's MAR lacked the above documentation. The facility failed to follow its policy regarding timely medication administration. b. On 4/11/09, nursing initiated a plan of care alteration in cardiac status. The plan indicated nursing would monitor Patient #6 for fluid overload. The patient weighed 464 pounds. On 4/13/09, the physician ordered daily weights. The facility failed to record daily weights on 4/14/09, 4/15/09, 4/17/09, 4/18/09, 4/21/09, 4/23/09, 4/25/09, 4/26/09, 4/28/09, and 4/29/09. On 5/1/09, the physician ordered daily weights again. The facility failed to record daily weights on 5/1/09, 5/2/09, 5/6/09, and 5/7/09. On 5/7/09, the physician ordered the patient's weight for the morning. The facility failed to record a weight on 5/8/09. The plan of care contained daily weight as a possible individualized intervention on a pre-printed form at admission on 4/11/09; the facility failed to include daily weight on its plan of	S 298	S298 Weights A. Orders for daily weights will be: documented on patient's Kardex, B. patients with daily weight will be identified on daily assignment sheet. Attachment #17 C: Review of documentation of daily weight will be done by Resource RN every shift and documentation of review on Resource RN Check List. Attachment # 15 D. CNO reviews above weekly E. CNO is responsible for monitoring corrective action F. Date of correction 6/11/098	

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S 298	Continued From page 7 care. The plan of care failed to document daily weights. On 5/8/09 at noon, Employee #1 indicated patient weights were either in the graphics section or possibly in the nursing progress notes. A review of Patient #6's graphics sections and daily nursing progress notes lacked documentation of daily weights. c. On 4/14/09, the physician ordered a 1000 milliliter fluid restriction. On 5/13/09 in the afternoon, the ordering physician indicated the restriction applied to fluids by mouth. A review of Patient #6's intake by mouth revealed the patient exceeded the 1000 milliliter restriction every day from 4/29/09 through 5/7/09. The facility did not update the plan of care to include fluid restriction as an individualized intervention after admission on 4/11/09. On 5/5/09, Patient #6 weighed 493 pounds. Patient #6 gained 29 pounds between admission on 4/11/09 and 5/5/09. The facility failed to properly monitor, record, and intervene with physician ordered interventions specific to Patient #6's alteration in cardiac status related to fluid overload. 2. a. Patient #7 On 5/6/09 in the morning, Employee #4 removed the following medications from the facility's medication dispenser/bulk supply for Patient #7: Intravenous lipids 20%/250 milliliters at 10:44 AM Oyster Shell/Vitamin D 500/200 at 10:47 AM	S 298	S 298: Monitoring of fluid intake for patients on fluid restriction A. Fluid restriction identified on Kardex and diet sheet. Fluid restriction sign will be posted on wall above bed in patient's room B. All have potential to be affected by deficient practice.. C. Fluid restriction documentation will be reviewed by Resource RN at end of each shift and document review on Resource RN Check List. Attachment # 15 D. CNO to review weekly E. CNO responsible compliance of corrective action F. Correction accomplished 6/11/09 Employee #4 written counseling on 5/17/09. 1:1 reviewed of medication administration policy, following physician orders for med administration, scheduled administration times, and Medication record documentation.	

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S 298	Continued From page 8 Prednisone 20 milligrams at 10:47 AM Pantoprazole 40 milligram vial at 10:47 AM .9 Sodium Chloride 100 milliliters at 10:47 AM Employee #26 removed .9 Sodium Chloride 100 milliliters and a Pantoprazole 40 milligram vial at 11:13 AM. The medication dispenser's activity report indicated the above medications with the above removal times for Patient #7. Patient #7's physicians' orders and MAR indicated the above medications were ordered to be administered at 9:00 AM. Chapter 5.003 of the facility's medication administration policy under sub-heading #10 indicated "medications are administered with one hour before and one hour after the scheduled time..." On 5/8/09 at 11:15 AM, Employee #1 indicated the medication parameters for 9:00 AM daily medications would be 8:00 AM to 10:00 AM, an hour before and an hour after 9:00 AM. Chapter 5.003 of the facility's medication administration policy under sub-heading #13 indicated "if a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time..., the space provided on the front of the [MAR] for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for [as needed] documentation."	S 298	S298 Medication Administration Employee # 26 Medication administration reviewed with employee including appropriate timing of distribution. Documented counsel: (Suspension). Medication test with 80% pass. Medication pass observation 6/9/09 with improvement opportunities identified and discussed. To seek medication education program to be completed by 6/30/09. Upon return from suspension (6/13/09) And complete review of SIX RIGHTS of MEDICATION ADMINISTRATION Attachment # 18	

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S 298	Continued From page 9 Patient #7's MAR lacked the above documentation. The facility failed to follow its policy regarding timely medication administration. The following was observed during Patient #7's intravenous (IV) Pantoprazole and Lipids administration: -Employee #26 primed the intravenous tubing with the .9 Sodium Chloride bag diluted with Pantoprazole. Afterward, Employee #26 indicated less than half of the Pantoprazole solution remained in the bag. Employee #26 then connected the IV tubing to Patient #7's IV port without cleaning the port. The IV fluid infused by gravity in less than fifteen minutes. Employee #26 clamped the IV tubing leaving the tubing attached to Patient #7 and returned with a second IV bag of .9 Sodium Chloride 100 millliliters and a second vial of Pantoprazole 40 milligrams. Employee #26 removed the tubing from Patient #7's IV port after spiking the new bag mixed with Pantoprazole. Employee #26 proceeded to prime the IV tubing a second time and reattached the IV tubing to Patient #7's IV port without cleaning the port. Employee #26 programmed the IV pump to infuse the 100 milliliter bag in one hour. The MAR indicated the Pantoprazole should infuse over 30 minutes.	S 298	Employee #26 IV fluids and IV medication delivery reeducation including aseptic technique reinforced through demonstration and return demonstration. Must be able to verbalize Infection control principles. Re educated regarding IV Pump function	

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S 298	Continued From page 10 The facility failed to follow a physician's order to administer an ordered medication with the proper dose at the proper rate. Employee #26 left the room and returned with the IV Lipids. At 11:53 AM, Employee #26 picked her personal keys off the floor after she had washed and gloved her hands. Employee #26 directly proceeded to flush Patient #7's IV port with 10 milliliters of saline without cleaning the port or removing her gloves and washing her hands again. On 5/8/09 at 11:15 AM, Employee #1 indicated the facility used 10 milliliter syringes with pre-filled saline for routine flushes. Nurses were supposed to use 5 milliliters before and 5 milliliters after an intravenous medication administration. The facility's intravenous catheter care policy, last reviewed June 2007, indicated the following regarding routine flushes for peripherally inserted central catheters: -Three milliliters normal saline followed by 3 milliliters of Heparin 100 units per milliliter. Patient #7's MAR indicated nurses administered 10 milliliters of saline with routine flushes and 5 milliliters of Heparin with routine flushes. The facility failed to follow its policy for routine flushing of peripherally inserted central catheters. The facility's infection control standard regarding intravenous therapy, last reviewed August 2007, indicated "aseptic techniques will be observed	S 298	S298 Intravenous care & flushes A. Intravenous Dressing and Catheter Care policy reviewed and revised 6-9-09. Attachment # 19 Reviewed Medex Produced by Pharmacy B. All patients receiving IV therapy have potential to be affected. C. All staff will be inserviced regarding Policy/Procedure IV Dressing and Catheter Care. Pharmacy Medex corrected 6/9/09 Attachment # 20 . D. Director of Pharmacy and CNO will share oversight. E CNO retains responsibility for monitoring compliance	

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	NVS2681HOS	A. BUILDING _____ B. WING _____	05/08/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROGRESSIVE HOSPITAL	4015 SOUTH MCLEOD LAS VEGAS, NV 89121

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S 298	Continued From page 11 during venipuncture and when entering the [intravascular] system." On 5/7/09 at 3:45 PM, Employee #28 indicated before accessing an IV line, a nurse should remove gloves, wash hands, and then re-glove after picking up objects off the floor with gloves on. IV ports should be swabbed with alcohol wipes before accessing them. On 5/8/09 at 10:50 AM, Employee #1 concurred with Employee #28 regarding aseptic technique and accessing an IV line. On 5/8/09 at 1:45 PM, Employees #31 and #32 concurred with Employees #1 and #28 regarding aseptic technique and accessing an IV line. The facility failed to use aseptic technique before accessing an IV port. The Lipids began infusing at noon, three hours after the scheduled time. The facility failed to follow its policy regarding timely medication administration. c. On 5/6/09, a physician's order indicated 125 milligrams of Solumedrol intravenous piggyback every 12 hours for 4 doses. On 5/6/09 at 3:19 PM, Employee #29 removed a 125 milligram/2 milliliter dose of Solumedrol, mixed it in an IV bag, and infused it. On 5/8/09 at noon, Patient #7's chart lacked documentation the patient received the Solumedrol. On 5/8/09 at noon, Patient #7's chart lacked a	S 298	S298 IV Medication administration Employee #29 1:1 review with regarding documentation of medication administration. Documented counsel regarding improvement opportunity. Verbalizes understanding of documentation process. Medication post test given with a minimum passing grade of 80%	

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S 298	Continued From page 12 physician's order discontinuing the Solumedrol. The facility failed to follow a physician's order to administer ordered Solumedrol and to document its administration. d. On 5/6/09 in the afternoon, Patient #7 was observed receiving a blood transfusion. The following data are from Patient #7's blood component's flow sheet completed during the observation: At 2:45 PM, Patient #7's baseline temperature was 99.6 degrees prior to the blood transfusion. At 3:00 PM, Patient #7's temperature was 102.3 degrees after initiation of transfusion. At 3:15 PM, Patient #7's temperature was 102.3 degrees. At 3:30 PM, Patient #7's temperature was 102.8 degrees. At 3:32 PM, the nurse stopped the transfusion. On 5/8/09 in the morning, Employee #1 indicated there was no reason to continue to transfuse blood in a patient with a 102 degree temperature unless a physician specifically ordered it. She further indicated the facility's temperature ceiling on transfusions might be 1-2 degrees above baseline. The facility's blood product administration policy regarding reactions, last reviewed February 2007, indicated the following: "1. A transfusion reaction is a physiological	S 298	S298 Blood Transfusion A: Blood transfusion policy to be reviewed by all licensed staff. B: Signature and date of review place on verification sheet. Attachment #23 C: CNO will observe 1 blood transfusion from time started to time end, monthly times 3 months then quarterly thereafter and report findings on report card. D: Blood transfusion reaction procedure reviewed with nurse involved. E: Documented counsel for nurse involved.	

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S 298	Continued From page 13 reaction to the infusion of blood or blood products. A reaction may consist of but [may] not [be] limited to: a. Temperature elevation of over 1 degree Celsius or 2 degrees Fahrenheit when not clinically expected. 2. If the patient is suspected of having a transfusion reaction, the following actions are to be taken: a. Stop the infusion of blood..." Patient #7's file lacked an order to continue transfusing with a temperature greater than 102. The nurse waited thirty-two minutes after Patient #7's temperature exceeded a two degree Fahrenheit temperature elevation to stop the transfusion. The facility failed to follow its blood product administration policy regarding reactions. 3. Patient #8 On 5/8/09 at 8:40 AM, Employee #32 administered 4 milligrams of intravenous Zofran to Patient #8. Patient #8 had a peripherally inserted central catheter in her left bicep. After administration, Employee #32 failed to use Heparin flush. The facility's intravenous catheter care policy, last reviewed June 2007, indicated the following regarding routine flushes for peripherally inserted central catheters: Three milliliters normal saline followed by three milliliters of Heparin 100 units per milliliter. Patient #8's MAR indicated Heparin flush per	S 298	S298 IV flushes Employee # 32 as identified on employee roster from State Licensure is a THC Pharmacist and as such would not be administering medications to patients. However A: Intravenous Dressing and Catheter Care policy reviewed and revised 6-9-09. Attachment # 19 B: Revised policy to be reviewed by all nurses with signature and date reviewed on verification sheet. Attachment #21	

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S 298	Continued From page 14 pharmacy protocol. Patient #8's MAR lacked documentation of Heparin use. The facility failed to follow its policy for routine flushing of peripherally inserted central catheters. 4. Patient #9 On 5/6/09 in the morning, Employee #4 removed the following medications from the facility's medication dispenser/bulk supply for Patient #9: Isosorbide Dinitrate 5 milligrams at 11:05 AM Lisinopril 10 milligrams at 11:08 AM Simvastatin 20 milligrams at 11:08 AM Lovenox 30 milligrams/.3 milliliters injection syringe at 11:09 AM Prednisone 20 milligrams at 11:11 AM Tamoxifen 10 milligrams at 11:15 AM Cipro 500 milligrams at 11:15 AM Employee #29 removed Furosemide 40 milligrams at 11:29 AM. The medication dispenser's activity report indicated the above medications with the above removal times for Patient #9. Patient #9's physicians' orders and MAR indicated the above medications were ordered to be administered at 9:00 AM. Chapter 5.003 of the facility's medication administration policy under sub-heading #10	S 298	S298 Medication Administration Employee #4 written counseling on 5/17/09. 1:1 reviewed of medication administration policy, following physician orders for med administration, scheduled administration times, and Medication record documentation. Employee # 29 1:1 review with regarding documentation of medication administration. Documented counsel regarding improvement opportunity. Verbalizes understanding of timely administration of medications	

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S 298	Continued From page 15 indicated "medications are administered with one hour before and one hour after the scheduled time..." On 5/8/09 at 11:15 AM, Employee #1 indicated the medication parameters for 9:00 AM daily medications would be 8:00 AM to 10:00 AM, an hour before and an hour after 9:00 AM. Chapter 5.003 of the facility's medication administration policy under sub-heading #13 indicated "if a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time..., the space provided on the front of the [MAR] for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for [as needed] documentation." Patient #9's MAR lacked the above documentation. The facility failed to follow its policy regarding timely medication administration. 5. Patient #12 A review of patients with recent blood transfusions yielded the following: On 5/6/09 in the afternoon, Patient #12's file revealed a transfusion order for two units of blood on 4/17/09. The order was accompanied by a second order to "give Lasix 20 milligrams intravenous between units." Patient #12's MAR documented two 20 milligram doses of intravenous Lasix, 20 milligrams between [two] units and another 20 milligrams after the second unit.	S 298	S298: Medication Lasix Documented counsel for nurse involved Reviewed six rights of medication administration on 6/11/09 and verbalized understanding. Completed medication test with a grade of 100	

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S 298	Continued From page 16 On 5/7/09 at 4:15 PM, Employee #28 indicated an order for 20 milligrams of Lasix between two units of blood means giving 20 milligrams of Lasix once. On 5/8/09 at 11:15 AM, Employee #1 indicated an order for 20 milligrams of Lasix between two units of blood means giving 20 milligrams of Lasix once. The facility failed to follow a physician's order and overdosed Patient #12 with Lasix. 6. Patient #14 On 5/6/09 in the morning, Employee #25 removed the following medications from the facility's medication dispenser/bulk supply for Patient #14 (who had a peripherally inserted venous catheter): .9% Sodium Chloride 100 milliliters at 11:38 AM Pantoprazole 40 milligram vial at 11:39 AM Patient #14's physicians' orders and MAR indicated the above medications were ordered to be administered at 9:00 AM. Chapter 5.003 of the facility's medication administration policy under sub-heading #10 indicated "medications are administered with one hour before and one hour after the scheduled time..." On 5/8/09 at 11:15 AM, Employee #1 indicated the medication parameters for 9:00 AM daily medications would be 8:00 AM to 10:00 AM, an hour before and an hour after 9:00 AM.	S 298	S298 Timely Medication Administration Employee # 25 Document written counseling 5/8/09. On 5-15 -09 @ the monthly nursing staff meeting medication administration reviewed with nurses. Post test given after review with a grade of 100%	

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S 298	Continued From page 17 Chapter 5.003 of the facility's medication administration policy under sub-heading #13 indicated "if a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time..., the space provided on the front of the [MAR] for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for [as needed] documentation." Patient #14's MAR lacked the above documentation. The facility failed to follow its policy regarding timely medication administration. During administration of the medication at 11:48 AM, Employee #25 proceeded to flush an IV port with 10 milliliters of saline prior to administering the IV bag with Pantoprazole. On 5/8/09 at 11:15 AM, Employee #1 indicated the facility used 10 milliliter syringes with pre-filled saline for routine flushes. Nurses were supposed to use 5 milliliters before and 5 milliliters after an intravenous medication administration. The facility's intravenous catheter care policy, last reviewed June 2007, indicated the following regarding routine flushes for peripherally inserted central catheters: Three milliliters normal saline followed by 3 milliliters of Heparin 100 units per milliliter. Patient #14's MAR indicated nurses administered 10 milliliters of saline with routine flushes and 5 milliliters of Heparin with routine flushes.	S 298	S 298 IV flushes Employee #25 Document written counseling 5/8/09. On 5-15 -09 @ the monthly nursing staff meeting medication administration reviewed with nurses. Revised IV P&P dated 6/9/09 reviewed Post test given after review with a grade of 100%	

S 298 General Summary

A. All individuals have been counseled and reeducated . All nursing staff members attended a mandatory nursing staff meeting in which all opportunities were discussed and medication administration process was reviewed and discussed.

B. All patients have the potential to be affected by the deficient practices

C. Review and revised P&P relating IV Catheter and dressing. Reviewed Blood Transfusion P&P, Medication Administration P&P, Infection Control P&P. Consulted with Pharmacy Manager concerning Medication Administration record improvement opportunities. Routinely schedule (monthly) Medication pass observation utilizing THC Pharmacist. Constructive counseling and discipline in progress.

D. CNO monitoring documentation of medication, IVs, and Blood transfusions in collaboration with Resource Nurse and Staff Management.

E. CNO Monitoring compliance with corrective action

F. Date of correction 6/30/09

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S 298	Continued From page 18 The facility failed to follow its policy for routine flushing of peripherally inserted central catheters. Severity: 2 Scope: 2	S 298	S335 NAC 449.363 Personnel, Policies 5/15/09 updated Management of Human Resources Plan –Attachment # 22. Developed Leadership Manual P&P "Licensure & Certification Verification" – Attachment # 23. Instituted formalized departmental P&P "Licensure & Certification Verification" for Nursing – Attachment # 24 Respiratory – Attachment # 25 Rehab: PT – Attachment # 26 OT – Attachment # 27 ST - Attachment # 28 Food Services – Attachment # 29 All employees and patients have potential of being affected by deficient practice. On 5/15/09, following survey exit conference, a management meeting was held to discuss improvement opportunities and to develop plan for correction. Above policies and procedure put into place to ensure deficient practice will not recur. 5/15/09 Executive Assistant to CEO developed master HR Log for tracking current licenses – Attachment # 30. Department Directors/Managers are responsible for monitoring and following appropriate and current P&P. P&P written and in place 5/15/09.	
S 335 SS=D	NAC 449.363 Personel Policies 1. A hospital shall have written policies concerning the qualifications, responsibilities and conditions of employment for each type of hospital personnel, including the licensure and certification of each employee when required by law. This Regulation is not met as evidenced by: Based on interview, document review and personnel record review the facility failed to ensure written policies were in place to verify licensure and certification of each employee when required by law. Findings include: On 05/07/09 at 10:00 AM, a review of the facility's Policies and Procedures Manuals revealed there was no documented evidence of a written policy and procedure for verification of employee licensure and certification at the facility. On 05/07/09 at 2:50 PM, Employee #1 confirmed the facility had no documented evidence of a written policy or procedure in place to verify licensure and certification of employees at the facility. The facility had no written policies or procedures in place to address employee license renewal, suspension, restriction or revocation. Employee #1 indicated all employees licenses were checked on-line by her on a quarterly basis to verify they were current and that information was sent to the Board of Nursing. Employee #1	S 335		

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S 335	Continued From page 19 indicated it was her responsibility to make sure current copies of employees licenses and CPR (cardiopulmonary resuscitation) certificates were placed in all employees files at the facility. 1. Employee # 4 was hired on 11/05/07 as a Licensed Practical Nurse (LPN). A copy of the employees LPN license located in the personnel file indicated the license expired on 10/27/08. There was no documented evidence of a current copy of the employees nursing license located in the employees personnel record. 2. Employee # 5 was hired on 11/27/06 as a Registered Nurse (RN). A copy of the employees RN license located in the personnel file indicated the RN license expired on 08/06/07. There was no documented evidence of a current copy of the employees nursing license located in the employees personnel record. A copy of the employees American Heart Association CPR card indicated an expiration date of 06/07. There was no documented evidence of a current CPR card in the employees personnel record. The facility's Job Description and Competency Evaluation for Registered Nurses and License Practical Nurses last revised on 10/08, indicated both Registered Nurses and Licensed Practical Nurses were required to have a current Nevada nursing license and current CPR. Severity : 2 Scope: 1	S 335	Continued S 335 from page 19 Employee #4 5/15/09 Current copy of LPN License removed from a to be filed pile in CNO office and placed in personnel file with NSBN computer verification – Attachment # 31. Employee # 5 5/15/09 Current copy of RN License removed from a to be filed pile in CNO office and placed in personnel file with NSBN computer verification – Attachment # 32. CPR Card 06/09 Attachment # 33 5/15/09 CNO verbally counseled regarding forward of personnel materials to the executive Assistant for timely filing. 6/4/09 Executive Assistant validated ALL EMPLOYEE FILES have current copy of appropriate licenses. And going forward notifies Directors/Manager of expirations within next 30, 60, 90 days– Attachment # 22 hilited yellow	
S 339 SS=D	NAC 449.363 Personel Policies 4. The hospital shall have evidence of a current license or certification on file at the hospital for each person employed by the hospital, or under contract with the hospital, who is required to be	S 339		

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S 339	Continued From page 20 licensed or certified by law to perform his job. This Regulation is not met as evidenced by: Based on interview, document review and personnel record review the facility failed to ensure two out of twenty four employees who were required to be licensed or certified by law had evidence of a current Nevada nursing license in their personnel record. (Employee #4, #5) Findings include: On 05/07/09 at 10:00 AM, a review of the facility's Policies and Procedures Manuals revealed there was no documented evidence of a written policy and procedure for verification of employee licensure and certification at the facility. On 05/07/09 at 2:50 PM, Employee #1 confirmed the facility had no documented evidence of a written policy or procedure in place to verify licensure and certification of employees at the facility. The facility had no written policies or procedures in place to address employee license renewal, suspension, restriction or revocation. Employee #1 indicated all employees licenses were checked on-line by her on a quarterly basis to verify they were current and that information was sent to the Board of Nursing. Employee #1 indicated it was her responsibility to make sure current copies of employees licenses and CPR (cardiopulmonary resuscitation) certificates were placed in all employees files at the facility. 1. Employee # 4 was hired on 11/05/07 as a Licensed Practical Nurse (LPN). A copy of the employees LPN license located in the personnel file indicated the license expired on 10/27/08. There was no documented evidence of a current copy of the employees nursing license located in the employees personnel record.	S 339	S 339 NAC 449.363 Personnel Policies 5/15/09 updated Management of Human Resources Plan –Attachment #22. Developed Leadership Manual P&P "Licensure & Certification Verification" – Attachment # 23. Instituted formalized departmental P&P "Licensure & Certification Verification" for Nursing – Attachment # 24 Respiratory – Attachment # 25 Rehab: PT – Attachment # 26 OT – Attachment # 27 ST - Attachment #28 Food Services – Attachment # 29 All employees and patients have potential of being affected by deficient practice. On 5/15/09, following survey exit conference, a management meeting was held to discuss improvement opportunities and to develop plan for correction. Above policies and procedure put into place to ensure deficient practice will not recur. 5/15/09 Executive Assistant to CEO developed master HR Log for tracking current licenses – Attachment # 30. Department Directors/Managers are responsible for monitoring and following appropriate and current P&P. P&P written and in place 5/15/09. Employee #4 5/15/09 Current copy of LPN License removed from a to be filed pile in CNO office and placed in personnel file with NSBN computer verification – Attachment # 31	

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S 339	Continued From page 21 2. Employee # 5 was hired on 11/27/06 as a Registered Nurse (RN). A copy of the employees RN license located in the personnel file indicated the RN license expired on 08/06/07. There was no documented evidence of a current copy of the employees nursing license located in the employees personnel record. The facility's Job Description and Competency Evaluation for Registered Nurses and License Practical Nurses last revised on 10/08, indicated both Registered Nurses and Licensed Practical Nurses were required to have a current Nevada nursing license. Severity: 2 Scope: 1	S 339	S 339 continued for page 21 Employee # 5 5/15/09 Current copy of RN License removed from a to be filed pile in CNO office and placed in personnel file with NSBN computer verification – Attachment # 32. CPR card 06/09 – Attachment #33 5/15/09 CNO verbally counseled regarding forward of personnel materials to the executive Assistant for timely filing. 6/4/09 Executive Assistant validated ALL EMPLOYEE FILES have current copy of appropriate licenses. And going forward notifies Directors/Manager of expirations within next 30, 60, 90 days – Attachment # 22 hilited yellow	
S 340 SS=F	NAC 449.363 Personel Policies 5. The hospital shall ensure that the health records of its employees contain documented evidence of surveillance and testing of those employees for tuberculosis in accordance with chapter 441A of NAC. This Regulation is not met as evidenced by: LCB File No. R084-06, Effective July 14, 2006 Sec. 10. NAC 441A.375 is hereby amended to read as follows: 441A.375 1. A case having tuberculosis or suspected case considered to have tuberculosis in a medical facility or a facility for the dependent must be managed in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 2. A medical facility, a facility for the dependent or a home for individual residential	S 340		

Bureau of Health Care Quality & Compliance

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	NVS2681HOS	A. BUILDING _____ B. WING _____	05/08/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROGRESSIVE HOSPITAL	4015 SOUTH MCLEOD LAS VEGAS, NV 89121

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S 340	Continued From page 22 care shall maintain surveillance of employees of the facility or home for tuberculosis and tuberculosis infection. The surveillance of employees must be conducted in accordance with the recommendations of the Centers for Disease Control and Prevention for preventing the transmission of tuberculosis in facilities providing health care set forth in the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 3. Before initial employment, a person employed in a medical facility, a facility for the dependent or a home for individual residential care shall have a: (a) Physical examination or certification from a licensed physician that the person is in a state of good health, is free from active tuberculosis and any other communicable disease in a contagious stage; and (b) Tuberculosis screening test within the preceding 12 months, including persons with a history of bacillus Calmette-Guerin (BCG) vaccination. If the employee has only completed the first step of a 2-step Mantoux tuberculin skin test within the preceding 12 months, then the second step of the 2-step Mantoux tuberculin skin test or other single-step tuberculosis screening test must be administered. A single annual tuberculosis screening test must be administered thereafter, unless the medical director of the facility or his designee or another licensed physician determines that the risk of exposure is appropriate for a lesser frequency of testing and documents that determination. The risk of exposure and corresponding frequency of examination must be determined by following the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph	S 340		

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S 340	Continued From page 23 (h) of subsection 1 of NAC 441A.200. 4. An employee with a documented history of a positive tuberculosis screening test is exempt from screening with skin tests or chest radiographs unless he develops symptoms suggestive of tuberculosis. 5. A person who demonstrates a positive tuberculosis screening test administered pursuant to subsection 3 shall submit to a chest radiograph and medical evaluation for active tuberculosis. 6. Counseling and preventive treatment must be offered to a person with a positive tuberculosis screening test in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (g) of subsection 1 of NAC 441A.200. 7. A medical facility shall maintain surveillance of employees for the development of pulmonary symptoms. A person with a history of tuberculosis or a positive tuberculosis screening test shall report promptly to the infection control specialist, if any, or to the director or other person in charge of the medical facility if the medical facility has not designated an infection control specialist, when any pulmonary symptoms develop. If symptoms of tuberculosis are present, the employee shall be evaluated for tuberculosis. Based on interview, record review and document review the facility failed to ensure that 23 out of 24 health records of its employees had documented evidence of a physical exam and surveillance testing of employees for tuberculosis in accordance with chapter 441 A of NAC. (Employees #1, #2, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23,#24) Findings include:	S 340	S 340 NAC 449.363 Personnel Policies All identified deficient will complete a two step Mantoux TB skin test and Physical indicating a state of good health & free from active TB & other communicable disease. All employees have potential to be effected by deficient practice.	

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S 340	Continued From page 24 On 05/06/09 at 12:30 PM, Employee #1 indicated she was not aware of the requirements of NAC 441A.375 and did not know that all employees were required to have a physical exam by a physician prior to employment that indicated the employee was in a good state of health and free from tuberculosis or any communicable disease. Employee #1 indicated the facility had no policy that required employees to complete a physical exam by a physician prior to participating in patient care. Employee #1 indicated she was not aware employees were required to have documentation of a 2-step tuberculin skin test prior to employment. 1. Employee #1 was hired on 10/02/02. There was no documented evidence of a two step Mantoux tuberculin skin test in the employees personnel file or physical examination or certification from a licensed physician that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease. 2. Employee #2 was hired on 06/08/05. There was no documented evidence of a two step Mantoux tuberculin skin test in the employees personnel file or physical examination or certification from a licensed physician that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease. 3. Employee #4 was hired on 11/05/07. A Tuberculin Testing for Employees form dated 03/29/08 indicated the employee had a positive 12 mm (millimeter) Mantoux tuberculin skin test. There was no documented evidence of a follow-up chest x-ray or tuberculin signs and	S 340	S 340 Continued from page 24 5/11/09 Review existing P&Ps relating to Physicals and TB testing. HR Management Plan updated to reflect 2 step TB test and physical processes – Attachment # 22 hilited green. Infection Control P&P appropriate and ICF/Employee Health Nurse counseled for not following P&P. 5/7/09 Physical Exam record designed and placed on the back of the existing Health File Medical Questionnaire – Attachment # 34. 6/5/09 revised TB Testing and Chest xray forms and made it two sided format. Attachments # 35 Employee # 1 2 step Mantoux TB skin test completed & filed 5/9/09 – Attachment # 36A Physical completed & filed 5/7/09 – Attachment # 36B Employee #2 2 step Mantoux skin test completed and filed 5/15/09 – attachment # 37A. Physical completed & filed 5/12/09 – attachment # 37B Employee # 4 Chest X-ray completed and filed 5/15/09 – Attachment # 38A Physical completed and filed 5/12/09 – Attachment # 38B	

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S 340	Continued From page 25 symptoms checklist in the employees personnel file. 4. Employee #5 was hired on 11/27/06. A facility Annual Chest X-Ray Follow-Up form dated 03/25/08 indicated the employee had a history of a reaction to a Mantoux tuberculin skin test and elected to have a chest x-ray. There was no documented evidence of an initial Mantoux tuberculin skin test result or chest x-ray result in the employees personnel file. There was no documented evidence of a physical examination or certification from a licensed physician that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease. 5. Employee #6 was hired on 05/08/03. There was no documented evidence of a physical examination or certification from a licensed physician in the employees personnel file that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease. 6. Employee #7 was hired on 04/07/09. There was no documented evidence of a physical examination or certification from a licensed physician in the employees personnel file that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease. 7. Employee #8 was hired on 05/11/05. There was no documented evidence of a two step Mantoux tuberculin skin test in the employees personnel file or physical examination or certification from a licensed physician that indicated the employee was in a good state of health and free from tuberculosis or any other	S 340	S 340 continued from page 25 Employee # 5 Chest x-ray 3/26/06 located, was missed filed. Annual updates 3/07, 3/08, 3/09 indicate no signs/symptoms of TB. Attachments # 39A Physical completed and filed 5/15/09 Attachment # 39B Employee # 6 2 step Mantoux TB skin test completed and filed 5/17/09 – Attachment # 40A Physical completed & filed 5/14/09 – Attachment # 40B Employee # 7 Physical completed and filed 5/15/09 – Attachment # 41 Employee # 8 2 step Mantoux TB skin test completed and filed 5/17/09 – Attachment # 42A Physical completed and filed 5/15/09 – Attachment # 42B	

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S 340	Continued From page 26 communicable disease. 8. Employee #9 was hired on 01/18/08. There was no documented evidence of a two step Mantoux tuberculin skin test in the employees personnel file or physical examination or certification from a licensed physician that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease. 9. Employee #10 was hired on 04/24/06. There was no documented evidence of a physical examination or certification from a licensed physician in the employees personnel file that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease. 10. Employee #11 was hired on 11/14/07. There was no documented evidence of a two step Mantoux tuberculin skin test in the employees personnel file or physical examination or certification from a licensed physician that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease. 11. Employee #12 was hired on 04/19/09. There was no documented evidence of a two step Mantoux tuberculin skin test in the employees personnel file or physical examination or certification from a licensed physician that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease. 12. Employee #13 was hired on 02/25/08. There was no documented evidence of a two step Mantoux tuberculin skin test in the employees	S 340	S 340 continued from page 26 Employee # 9 2 step Mantoux TB skin test completed and filed 5/16/09 – Attachment # 43A Physical completed and filed 5/14/09 – Attachment # 43B Employee # 10 Physical completed and filed 5/12/09 Attachment # 44 Employee # 11 2 step Mantoux TB skin test completed and filed 5/21/09 – Attachment # 45A Physical completed and filed 5/15/09 Attachment # 45B Employee # 12 2step Mantoux TB skin test completed and filed 5/18/09 – Attachment # 46A Physical completed and filed 5/12/09 – Attachment # 46B Employee # 13 2 step Mantoux TB skin test completed and filed 5/18/09 – Attachment # 47A Physical completed and filed 5/15/09 Attachment # 47B	

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S 340	Continued From page 27 personnel file or physical examination or certification from a licensed physician that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease. 13. Employee #14 was hired on 10/14/08. There was no documented evidence of a physical examination or certification from a licensed physician in the employees personnel file that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease. 14. Employee #15 was hired on 03/01/07. There was no documented evidence of a physical examination or certification from a licensed physician in the employees personnel file that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease. 15. Employee #16 was hired on 09/18/08. There was no documented evidence of a two step Mantoux tuberculin skin test in the employees personnel file or physical examination or certification from a licensed physician that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease. 16. Employee #17 was hired as a Registered Dietician. There was no documented evidence of a two step Mantoux tuberculin skin test in the employees personnel file or physical examination or certification from a licensed physician that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease.	S 340	S 340 continued from page 27 Employee # 14\ Physical completed and filed 5/14/09 – attachment # 48 Employee # 15 Physical completed and filed 5/14/09- Attachment # 49 Employee # 16 1st step Mantoux TB skin test completed and filed 3/29/09 – Attachment # 50A Resigned employment 4/21/09 – Attachment # 50B Employee # 17 2 step Mantoux TB skin test completed and filed 5/14/09 – Attachment # 51A Physical completed and filed 6/5/09 – Attachment # 51B	

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S 340	Continued From page 28 17. Employee #18 was hired as a Registered Dietician. There was no documented evidence of a two step Mantoux tuberculin skin test in the employees personnel file or physical examination or certification from a licensed physician that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease. 18. Employee #19 was hired on 06/27/06. There was no documented evidence of a two step Mantoux tuberculin skin test in the employees personnel file or physical examination or certification from a licensed physician that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease. 19. Employee #20 was hired on 01/03. There was no documented evidence of a two step Mantoux tuberculin skin test in the employees personnel file or physical examination or certification from a licensed physician that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease. 20. Employee #21 was hired on 03/09. There was no documented evidence of a physical examination or certification from a licensed physician in the employees personnel file that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease. 21. Employee #22 was hired on 11/03. There was no documented evidence of a two step Mantoux tuberculin skin test in the employees personnel file or physical examination or certification from a licensed physician that indicated the employee was in a good state of health and free from	S 340	S 340 continued from page 28 Employee # 18 2 step Mantoux TB skin test completed and filed 6/10/09 – Attachment # 52A Physical completed and filed 6/10/09 – Attachment # 52B Employee # 19 2 step Mantoux TB skin test completed and filed 5/14/09 – Attachment # 53A Physical completed and filed 5/12/09 – Attachment # 53B Employee # 20 2 step Mantoux TB skin test completed and filed 5/16/09 – Attachment # 54A Physical completed and filed 5/14/09 – Attachment # 54B Employee # 21 Physical completed and filed 5/18/09 – Attachment # 55 Employee # 22 2 step Mantoux TB skin test completed and filed 5/16/09 – Attachment # 56A Physical completed and filed 5/14/09 – Attachment # 56B	

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S 340	Continued From page 29 tuberculosis or any other communicable disease. 22. Employee #23 was hired on 08/08. There was no documented evidence of a two step Mantoux tuberculin skin test in the employees personnel file or physical examination or certification from a licensed physician that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease. 23. Employee #24 was hired on 01/06. There was no documented evidence of a two step Mantoux tuberculin skin test in the employees personnel file or physical examination or certification from a licensed physician that indicated the employee was in a good state of health and free from tuberculosis or any other communicable disease. The facility's Infection Control Policy last revised 10/08 documented the following: "All healthcare facility personnel will receive a Mantoux intradermal tuberculin skin test on employment and before patient care contact is initiated unless a previously positive reaction, completion of adequate prophylactic chemotherapy, or completion of an adequate therapeutic regime for active disease can be clearly documented. A two-step tuberculin screening test will be used in all new employees who have not had a documented recent tuberculin test within the last 12 months." Severity: 2 Scope: 3	S 340	S 340 continued from page 29 Employee # 23 2 step Mantoux TB skin test submitted filed 7/17/08. – Attachment # 57A Annual 3/26/09 – Attachment # 57B Physical completed and filed5/15/09 – Attachment # 57C Employee # 24 2 step Mantoux TB skin test completed and filed 5/16/09 – Attachment # 58A Physical completed and filed 5/14/09 – Attachment # 58B Executive Assistant to CEO is responsible to maintain a master HR log for tracking required personnel file information. Executive Assistant notifies Directors/Managers monthly of expiring documents within the next 30, 60, 90 days. Director/Managers are responsible to obtain current documents and pass then to Executive Assistant for timely filing. Attachment # 22 see hilited information relating to licensure, TB skin tests and physicals. 6/10/09 Executive Assistant has validated all facility employee personnel files have appropriate current licenses, TB tests and physicals – Master Log Attachment # 59. No new employee or existing employee is allowed to work without current required documentation in personnel file. Reference copy of Chapter 441 is housed in CEO office and has been reviewed by management	